अण्डमान तथा निकोबार राजपत्र

Andaman And Nicobar Gazette

सत्यमेव जयते

असाधारण

EXTRAORDINARY

प्राधिकार से प्रकाशित

Published by Authority

सं. 140, पोर्ट ब्लेयर, सोमवार, 1 अगस्त, 2005

No. 140, Port Blair, Monday, August 1, 2005

अण्डमान तथा निकोबार प्रशासन

ANDAMAN AND NICOBAR ADMINISTRATION

सचिवालय/SECRETARIAT

NOTIFICATION

Port Blair, dated the 1st August, 2005.

No. 136/05/F.No. 34-13/2004-MPH.—In exercise of the powers conferred by sub-section 2 of section10 of Registration of Birth & Death Act, 1969 (18 of 1969), the Lieutenant Governor (Administrator), Andaman & Nicobar Islands, having regard to facilities available in the areas specified hereunder, hereby requires the Medical Practitioners who attended the deceased during the last illness to issue medical certificate as to the cause of death (in the specified form 4 or 4A) in the following (areas/hospitals) with effect from the date of publication of this notification, namely:—

1. (i) All hospitals including Nursing and Maternity Homes whether managed by public or private organization and Societies of Urban and Rural areas of the Andaman District and Nicobar District of this Union Territory

   (AND/OR)

   (ii) All private medical practitioners of urban area of the Andamans District of Andaman and Nicobar Union Territory.
2. These institutions shall present the Medical Certificate as to the cause of death in Form 4 to the concerned Registrar of Birth & Death at the time of giving information of death as required under the said Act.
3. In case of domiciliary events, the private medical practitioners shall provide Medical Certificate as to the cause of death to the relative of the deceased in Form 4A to furnish it to the concerned Registrar of Birth & Death at the time of giving information of death.

By order of the Lieutenant Governor,

Sd/-
Assistant Secretary (Health)

FORM No. 4

(*See Rule 7)*

MEDICAL CERTIFICATE OF CAUSE OF DEATH

(Hospital In-patients Not to be used for still births)

To be sent to Registrar alongwith Form No.2 (Death Report)

Name of the Hospital.....

I hereby certify that the person whose particulars are given below died in the hospital in Ward No..... on..... at.....AM/PM.

Name Of Deceased.....					For use of Statistical Office
Sex	Age of Death				
	If 1 year or more, age in years	If less than 1 year, age in month	If less than one month, age in days	If less than one day, age in hours	
1. Male 2. Female					

CAUSE OF DEATH			
I Immediate cause State the disease, injury or complication which caused death, not the mode of dying such as heart failure, asthenia, etc.	(a) ..... Due to (or as a consequences of)		Interval between onset and death approx.
Antecedent cause Morbid conditions, if any, giving rise to the above cause, stating underlying conditions last	(b) ..... Due to (or as a consequences of)		
If Other significant conditions contributing to the death but not related to the disease or condition causing it	(c)		

Manner of Death — How did the injury occur ?

1. Natural, 2. Accident, 3. Suicide, 4.Homicide
5. Pending investigation

If deceased was a female, was pregnancy the death associated with ?	1. Yes	2. No
If yes, was there a delivery ?	1. Yes	2. No

Name and signature of the Medical Attendant certifying the cause of death

Date of verification.....

(To be detached and handed over to the relative of the deceased)

Certified that Shri/Smti./Kum.....

S/W/D of Shri.....R/o.....

was admitted to this hospital on .....and expired on.....

Doctor.....
(Medical Supdt.
Name of Hospital)

FORM No. 4A

(*See Rule 7)*

MEDICAL CERTIFICATE OF CAUSE OF DEATH

(For non-institutional deaths. Not to be used for still births)
To be sent to Registrar alongwith Form No.2 (Death Report)

I hereby certify that the deceased Shri/Smti./Kum..... son/wife/daughter of.....R/o.....

was under my treatment from.....to..... and he/she died on ..... at.....AM/PM.

Name Of Deceased.....					For use of Statistical Office
Sex	Age of Death				
	If 1 year or more, age in years	If less than 1 year, age in month	If less than one month, age in days	If less than one day, age in hours	
1. Male 2. Female					
CAUSE OF DEATH					
I Immediate cause State the disease, injury or complication which caused death, not the mode of dying such as heart failure, asthenia, etc.	(a) ..... Due to (or as a consequences of)			Interval between onset and death approx.	
Antecedent Cause Morbid conditions, if any, giving rise to the above cause, stating underlying conditions last	(b) ..... Due to (or as a consequences of)				
If Other significant conditions contributing to the death but not related to the disease or condition causing it	(c)				

If deceased was a female, was pregnancy the death associated with ? 1. Yes 2. No
If yes, was there a delivery ? 1. Yes 2. No

Name and signature of the Medical Attendant certifying the cause of death

Date of verification.....

(To be detached and handed over to the relative of the deceased)

Certified that Shri/Smt./Kum.....
S/W/D of Shri.....R/o.....
was under my treatment from .....to..... and he/she expired on..... at .....AM/PM.

Doctor.....
Signature and address of Medical Practitioner/
Medical attendant with Registration No.

MGPPB—140/Gazette/2005— 75 Copies (140-Gazette-05 SB)